



Employee Name: \_\_\_\_\_

(4) Give your **best estimate** of the amount of leave needed to provide the care described: \_\_\_\_\_

(5) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced schedule you are able to work.

From \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy), I am able to work \_\_\_\_\_ hours a day for \_\_\_\_\_ (days per week).

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_ (mm/dd/yyyy)

### SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, **complete all relevant parts of this Section**, and sign the form below. A family member of your patient has requested leave under the CTFMLA to care for your patient. The CTFMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for CTFMLA leave to care for a family member with a serious health condition. For CTFMLA purposes, a “serious health condition” means an illness, injury, impairment, or physical or mental condition that *involves inpatient care or continuing treatment by a health care provider*. For more information about the definitions of a serious health condition under the CTFMLA, see the chart at the end of the form.

You should provide other appropriate medical facts including symptoms or any regimen of continuing treatment such as the use of specialized equipment, but you are not required to provide a diagnosis.

Health Care Provider’s name: (Print) \_\_\_\_\_

Health Care Provider’s business address: \_\_\_\_\_

Type of practice / Medical specialty: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

#### **PART A: Medical Information**

Limit your response to the medical condition for which the employee is seeking CTFMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For CTFMLA purposes, “incapacity” means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, genetic services, or the manifestation of disease or disorder in the employee’s family members.

(1) Patient’s Name: \_\_\_\_\_

(2) State the approximate date the condition started or will start: (mm/dd/yyyy) \_\_\_\_\_

Provide your **best estimate** of how long the condition lasted or will last: \_\_\_\_\_

(3) For CTFMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient.

\_\_\_\_\_  
(e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort)

(4) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B. (see “Definitions of Serious Health Condition” chart at the end of the document for more detailed explanation)

**Inpatient Care:** The patient ( has been /  is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): \_\_\_\_\_

**Incapacity plus Treatment:** (e.g., outpatient surgery, strep throat)

Due to the condition, the patient ( has been /  is expected to be) incapacitated for **more than** three consecutive, full calendar days from \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy).

The patient ( was /  will be) seen on the following date(s): \_\_\_\_\_

\_\_\_\_\_  
The condition ( has /  has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g., prescription medication (other than over-the-counter) or physical therapy)

Employee Name: \_\_\_\_\_

- Pregnancy:** The condition is pregnancy. List the expected delivery date: \_\_\_\_\_ (mm/dd/yyyy).
- Chronic Conditions:** (e.g., asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.
- Permanent or Long-Term Conditions:** (e.g., Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).
- Conditions requiring Multiple Treatments:** (e.g., chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.
- None of the above:** If none of the above condition(s) were checked, no additional information is needed. Go to page 4 to sign and date the form.

(5) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks CTFMLA leave. (e.g., use of nebulizer, dialysis) \_\_\_\_\_

**PART B: Amount of Leave Needed**

For the medical condition(s) checked in Part A, complete all that apply. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine if the benefits and protections of the CTFMLA apply.

(1) Due to the condition, the patient ( had /  will have) **planned medical treatment(s)** (scheduled medical visits) (e.g. psychotherapy, prenatal appointments) on the following date(s): \_\_\_\_\_

(2) Due to the condition, the patient ( was /  will be) **referred to other health care provider(s)** for evaluation or treatment(s). State the nature of such treatments: (e.g. cardiologist, physical therapy) \_\_\_\_\_  
Provide your **best estimate** of the beginning date \_\_\_\_\_ and \_\_\_\_\_ end date (mm/dd/yyyy) for the treatment(s). Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery \_\_\_\_\_ (e.g. 3 days/week)

(3) Due to the condition, the patient ( was /  will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery. Provide your **best estimate** of the beginning date: \_\_\_\_\_ (mm/dd/yyyy) and end date \_\_\_\_\_ (mm/dd/yyyy) for the period of incapacity.

(4) Due to the condition, it ( was /  is /  will be) medically necessary for the employee to be absent from work to provide care for the patient on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last. Over the next 6 months, episodes of incapacity are estimated to occur \_\_\_\_\_ times per ( day /  week /  month) and are likely to last approximately \_\_\_\_\_ ( hours / days) per episode.

**Signature of Health Care Provider:** \_\_\_\_\_

**Date** \_\_\_\_\_ (mm/dd/yyyy)

Employee Name: \_\_\_\_\_

<b>Definitions of a Serious Health Condition</b>
<b>Inpatient Care</b>
<ul style="list-style-type: none"><li>• An overnight stay in a hospital, hospice, or residential medical care facility.</li><li>• Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.</li></ul>
<b>Continuing Treatment by a Health Care Provider (any one or more of the following)</b>
<b>Incapacity Plus Treatment:</b> A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: <ul style="list-style-type: none"><li>• Two or more in-person or telemedicine visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or,</li><li>• At least one in-person or telemedicine visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.</li></ul>
<b>Pregnancy:</b> Any period of incapacity due to pregnancy or for prenatal care.
<b>Chronic Conditions:</b> Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
<b>Permanent or Long-term Conditions:</b> A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer’s disease or the terminal stages of cancer.
<b>Conditions Requiring Multiple Treatments:</b> Restorative surgery after an accident or other injury; or a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

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**DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR.  
RETURN TO THE PATIENT.**

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